IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7005 1160 0000 1506 8950

July 2, 2008

John A. Schulkins, Administrator
Caldwell Care Center
210 Cleveland Boulevard
Caldwell, ID 83605

Provider #: 135014

Dear Mr. Schulkins:

On **June 20, 2008**, a Recertification and State Licensure survey was conducted at Caldwell Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 15, 2008**. Failure to submit an acceptable PoC by **July 15, 2008**, may result in the imposition of civil monetary penalties by

August 4, 2008.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 25, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 25, 2008**. A change in the seriousness of the deficiencies on **July 25, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 25, 2008** includes the following:

Denial of payment for new admissions effective **September 20, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 20, 2008**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 20, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **July 15, 2008**. If your request for informal dispute resolution is received after **July 15, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135014	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/20/2008
NAME OF PROVIDER OR SUPPLIER **CALDWELL CARE CTR**	STREET ADDRESS, CITY, STATE, ZIP CODE **210 CLEVELAND BOULEVARD CALDWELL, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) CLINICAL RECORDS

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review, it was determined the facility failed to document a lap buddy evaluation for Resident #12 and document discharge planning for Resident #15. This was true for 2 of 15 (#s 12 & 15) sampled residents. Findings include:

1. Resident #12 was admitted to the facility on 2/21/08 with diagnoses of psychosis, dementia with behaviors, anemia, gastroesophageal reflux disease, hypothyroidism, mood disorder, and status post hip fracture.

The most recent quarterly MDS assessment, dated 5/30/08, documented the resident as having:
*short and long term memory problems,
*severely impaired cognitive skills for daily decision making,
*wandering tendencies,
*bladder incontinence,
*extensive assistance with one person assist for ADLs,
*unsteady gait,
*hip fracture in last 180 days,
*other fracture in last 180 days,
*falls in the last 30 days and within the last 31 to 180 days.

Resident #12 had experienced a fall on 3/6/08 with no apparent injury noted. A Resident Progress Notes entry on 3/8/08 at 12:30 pm for the resident documented, "wears lap buddy prn [as needed] for safety." Another entry, by the same LN on 3/19/08 at 10:00 am, documented, "Lap buddy prn for safety." The surveyor did not observe the resident with a lap buddy at any time during the survey.

During an interview on 6/19/08 at 3:20 am, the DON stated that the lap buddy and merry walker had been evaluated on a trial basis in the physical therapy (PT) department. He stated both interventions were deemed unsuitable by PT for the resident's use and documentation of those results would be in the PT notes.

A Physical Therapy Progress Note documented on 3/14/08, "assisted OT [occupational therapy] /c [with] merry walker trial. Merry walker not an appropriate device for patient." However, no documentation for the lap buddy evaluation was found in the Physical Therapy Progress Notes or in the Resident Progress Notes.

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F 514	Continued From Page 1 2. Resident #15 had been admitted to the facility on 2/26/07 with diagnoses of hip fracture, dementia, anxiety, diabetes mellitus and anxiety. He was discharged from the facility on 4/4/08 to his home. The resident's record did not contain information from Social Services related to planning for his discharge home. During interview on 6/19/08 at 2:30 p.m. the Social Worker produced a Discharge Summary/Transfer Sheet, dated 4/4/08, which included nursing information. The form had a place for Social Services information, including post discharge services needed. The Social Worker stated the family was involved in the discharge planning, as well as a Home Health agency, but documentation of the planning was not completed in the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135014	A. BUILDING _____ B. WING _____	06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALDWELL CARE CTR	210 CLEVELAND BOULEVARD CALDWELL, ID 83605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual Recertification survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Rhonda Olsen, RN Lea Stoltz, QMRP Amanda Bain, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL 16 2008	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined the facility failed to maintain and enhance the privacy and dignity of residents. This was true for 1 of 13 sampled residents (#5) and residents using the west park bathroom. Resident #5 sat for an extended period of time unattended, and privacy and dignity were compromised for all residents using the west park unisex bathroom. Findings include:	F 241	FACILITY STANDARDS F241 **Resident Specific** The ID (inter-disciplinary) team reviewed resident # 5's plan of care related to waking in the mornings and timely assistance with toileting. Additionally, the ID team will make changes to the West unit community bathroom so as to ensure dignity. Changes will include creating a private bathroom for one resident at a time to eliminate co-ed usage. **Other Residents** The ID team reviewed other residents for dignity concerns with intervention as indicated. As mentioned above, physical	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Schultheis	Executive Director	15 JUL 2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 1. Resident #5 was admitted to the facility on 5/8/07 with diagnoses of bipolar disorder, renal artery stenosis, diabetes mellitus, and osteoporosis. On 6/17/08 Resident #5 was observed up and dressed in her wheelchair, seated in the west park lobby, at 6:00 a.m. She was asleep in the wheelchair, without interaction, until 7:10 a.m., at which time a CNA wheeled her to a table in the lobby for breakfast. After the meal, the resident again slept in the wheelchair from 7:40 a.m. until a CNA wheeled her to her room at 8:10 a.m. When 2 CNAs transferred her from the wheelchair to the commode at her bedside, she stated "I'm wet." The seat of the wheelchair was observed to contain a puddle of urine. The DON and RN consultant were informed of the observation on 6/18/08 at 2:25 p.m. No further information was communicated. 2. A resident group interview was conducted on 6/17/08 at 10:00 a.m. Ten women and 4 men were in attendance. When asked about the building in general, several residents expressed dissatisfaction with the state of the west park bathroom. They stated it was used by both men and women, and the women expressed concern and were unhappy with sharing the bathroom with the men. Residents also expressed displeasure with the fact that one of the 2 stalls did not have a solid door, but only a cloth pull curtain on the stall. Of the 17 resident rooms in the west park wing of the facility, 7 rooms were without in-room bathrooms. Of those 7 rooms 5 were 4 bed occupancy rooms, resulting in the potential for the	F 241	plant changes to the community bathroom on West unit will be completed. **Facility Systems** Staff are re-educated and supervised to implement each resident's individualized plan of care to include but not limited to, waking hours and toileting. Re-education was provided related to assisting residents timely with cares and avoiding prolonged sleeping in a wheel chair. Additionally, bathrooms in the facility are being adjusted to provide adequate dignity. **Monitor** The Director of Nurses (DNS) and/or designee will review one resident weekly for proper implementation of the plan of care to include but not limited to, timely provision of care and appropriate dignity. Any concerns will be addressed immediately and discussed with the PI (Performance Improvement) committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 25,2008	

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F 241	Continued From page 2 majority of residents on the wing to be required to use the communal, unisex bathroom. Immediately after the meeting, survey staff observed the bathroom on the west wing. The room was as the residents described, with only a cloth curtain on one stall. Further observation during the survey revealed the room in use by both men and women. The DON, Administrator and RN consultant were informed of the observation on 6/17/08 at 2:30 p.m. The DON and RN consultant stated the curtain had been put in place as a result of wheelchair transfers being difficult with the solid door in place, and the privacy of residents using wheelchairs being compromised in the past.	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to store assistive equipment in personal space readily accessible to the resident for 1 of 13 sampled residents (#2). Findings include: Resident #2 was admitted to the facility with diagnoses of dementia, depression, diabetes mellitus, hypertension, cerebrovascular accident,	F 246	F246 **Resident Specific** The ID team reviewed resident # 2's plan of care related to assistance with the walker and storing it by the bedside. Of note, resident # 2 is ambulatory without assistance and is frequently placing his walker out of reach from his bed. The plan of care is updated to reflect his current needs in order to accommodate him. **Other Residents** The ID team reviewed other residents with assistive devices to validate accommodation of need including proper storage. The plans of care were updated as indicated. In-service education will be provided to direct care staff regarding the need to	

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F 246	Continued From page 3 and aphasia. The most recent quarterly MDS assessment, dated 6/4/08, documented the resident as having: *short and long term memory problems, *persistent anger with self and others, *verbal abusive tendencies, *resistance to care giving efforts, *need for extensive assistance with ADLs, *conditions/diseases making cognitive, ADL, mood or behavior patterns unstable. The resident's Comprehensive Care Report, dated 3/27/08 with a 9/4/08 goal date, documented the problem of impaired physical mobility with right sided weakness. One of the approaches listed was, "ambulate as tolerated using FWW [front wheel walker] with 1 assist." On 6/17/08 at 6:30 am, the surveyor observed Resident #2's labeled walker stored in the room mate's area approximately 10 feet away from the resident's bed. The CNA assisting the resident with ADLs pulled the walker from the room mate's area for the resident to use. The walker was again observed stored in the same area on 6/18/08 at 8:00 am. The CNA providing cares for Resident #2 on 6/17/08 and 6/18/08 was interviewed on 6/18/08 at 10:30 am. She stated the evening CNAs had been reminded to put Resident #2's walker by his bed for easier access, but had not been doing it consistently. During the observations on 6/17/08 and 6/18/08, the surveyor noted the resident's repeated refusals for ADL assistance from the CNAs when help appeared appropriate. Storing the walker out	F 246	accommodate need including, but not limited to storing assistive devices properly and not encroaching on the personal space of other residents. **Facility Systems** Residents are assessed upon admission, with change of condition and at least quarterly. A plan of care is prepared to monitor that adequate care is provided and needs are accommodated. The licensed nursing (LN) staff supervises constantly to monitor for appropriate accommodation of need for each resident. **Monitor** The Director of Nurses (DNS) and/or designee will review at least one resident weekly for proper implementation of the plan of care to include but not limited to, accommodation of need including proper storage of assistive devices. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 25, 2008 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any	

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F 246	Continued From page 4 of the reach from the bed increased the fall risk for someone, such as Resident #2, unlikely to call for assistance.	F 246	statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all	
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure a homelike environment. This affected Resident #5's and #11's rooms, which were devoid of personal items and decor, and all residents who dined in the west park lobby. Findings include: 1. Resident #5 was admitted to the facility on 5/8/07 with diagnoses of bipolar disorder, renal artery stenosis, diabetes mellitus, and osteoporosis. On 6/16/08 Resident #5 was observed in her room in bed at 2:45 p.m. The resident's area of the 4 bed room contained a bed, bedside commode and an end table with a television set on it. The area was devoid of pictures or other personal items. On 6/17/08 at 8:20 a.m. 2 CNAs were asked why some of the residents sharing the room had personal items on display, but Resident #5 did not. The CNAs stated the only time resident's bedrooms were decorated was when the family came in and did it. 2. Breakfast and/or lunch meals were observed in the west park lobby on 6/16/08, 6/17/08 and	F 252	deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 252 **Resident Specific** The ID team reviewed resident #'s 5 & 11 related to personalized décor in their rooms. Adjustments were made. Additionally, residents dining in the West unit family room will be served with conditions of equal décor as the main dining room. Additionally, the family room was previously painted and is undergoing a décor update. **Other Residents** The ID team reviewed current resident rooms to validate they were adequately decorated and personalized. Dining was observed in all the dining areas to validate equality in approach and comfort. **Facility Systems** Residents are assessed and observed upon admission. Social services works directly with the resident and/or significant other to arrange for comfortable and homelike décor for the resident room. When indicated, additional décor is provided by the facility to establish a home-like environment. **Monitor** The administrator or designee will review rooms of newly admitted residents weekly as well as a dining area to ensure a	

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F 252	Continued From page 5 6/18/08. The lobby walls were bare of pictures or art, the 2 tables used for dining were bare of tablecloths or flowers, and the area was open to the corridor from resident rooms to the Train Depot dining room. In contrast, the Train Depot dining room tables had tablecloths and floral arrangements. Residents in the lobby were served meals on the trays. In contrast, in the Train Depot dining room plates and utensils were moved from the trays to the tables prior to residents dining. The DON, Administrator and RN consultant were informed of the observation on 6/18/08 at 2:30 p.m. No further information was provided.	F 252	comfortable and homelike environment. Any concerns will be corrected immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring as it deems appropriate. **Date of Compliance** July 25, 2008 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility did not ensure that all hallways remained free of clutter, areas were well painted, and upholstered surfaces and moldings remained in good repair. The facility also did not ensure that the west hallway water fountain, fan in the nurses station, or west wing bathroom were clean. The west hallway bathroom and shower room were also in need of repairs. Findings include: a. On 06/16/08 at 10:55 am, in room 218, it was observed that all four shelves on a wooden wall mounted shelving unit had missing paint.	F 253	F253 **Resident Specific** The facility will paint the shelves in rm # 218, repair the molding in the east entry and rm #108, clean the water fountain on the west hall, replace the molding behind the hand rails near the dining rooms, remove the fan and/or clean it in the West nursing station, clean and repair the west shower room, clean the bathroom on west hall, requisition for floor replacement for the west hall bathroom, repair the paint in rm #102, remove items from halls when not in use to avoid clutter, and repair the	

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F 253	Continued From page 6 b. On 06/16/08 at approximately 3:00 pm, it was observed that the base molding in the east entry area was missing and in need of repair. c. On 06/17/08 at 6:50 am, it was observed the fountain in the west hallway was dirty with obvious debris located in the sink area. d. On 06/17/08 at 7:00 am, it was observed in room 108, that there was a piece of corner molding missing from the resident's wall and found piled under the sink. e. During the initial and subsequent tours of the facility, multiple areas of trim molding were noted to be missing behind the facility's handrails. On 06/17/08 at 7:00 am, it was observed that molding areas were missing near the Train Depot and Gardenia dining areas. f. On 06/17/08 at 7:50 am, it was observed that the fan in the west hallway nurses station was covered with dust and was blowing on to the medication cart. g. On 06/17/08 at 10:50 am, it was observed that the shower room in west hallway was unlocked. The entire shower room was in need of painting, and the shower tile was in need of cleaning and repairing. The DON entered the shower room and secured the lock. h. On 06/17/08 at 11:00 am, it was observed that the bathroom in the west hallway was unsanitary and in need of repair. The room smelled strongly of urine. The floor tile in the second stall to the right side of the toilet was broken exposing the wooden boards and cement floor. The bathroom stall door was missing on the first stall, replaced	F 253	upholstery on the west unit wall/bench and resident # 8's chair. **Other Residents** The administrator and maintenance director rounded in the center to identify any other items requiring repair and validating a clutter free environment. In-service education will be provided to facility staff regarding the need to keep the environment clear of clutter and reporting maintenance concerns timely. **Facility Systems** Equipment and other items will be cleared from the corridors when not in immediate use to avoid clutter. The maintenance director and administrator complete daily, weekly and monthly preventative maintenance rounds addressing concerns observed in the environment. A binder will be made available at each nursing station containing maintenance request/alert sheets. These sheets will allow staff easy access for reporting additional observed concerns in the environment requiring intervention. The maintenance director will round during regular workdays to check for alerts and prioritize repairs as indicated. **Monitor** The administrator and/or designee will round in the center at least weekly to observe the environment and monitor for a clutter free environment in adequate repair. Any concerns will be addressed immediately and discussed with the PI	

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F 253	Continued From page 7 only by a cloth curtain for privacy. The entire room was in need of paint. i. On 06/18/08 at 11:40 am, it was observed that in room 102 a fist size area of paint was peeling from the wall adjacent to the resident's bed. j. On 06/17/08 at 6:05 am, it was observed that a dynamap (vital signs machine) was unattended and adjacent to the nurses station in the west hallway. At 6:50 am, the dynamap was removed from the hallway. k. On 06/17/08 at 6:10 am, the upholstery on a blue vinyl pad, on the wall adjacent to the social worker's office, in the west hallway, was observed to be torn and in need of repair. The upholstery on a green bench, also located in the west hallway, was torn and observed to be in need of repair. l. On 06/17/08 at 7:00 am, it was observed that five large clean linen laundry carts, two smaller upright linen carts, one paper shredder can, and a housekeeping cart with mop bucket, were parked in the hallway adjacent to the beauty shop. The floor was wet only in front of the beauty shop and wet floor caution signs were posted in the area. Residents were observed navigating through the cluttered hallway toward the Train Depot dining room for breakfast. m. On 06/18/08 at 10:15 am, it was observed that a resident was upset and complaining to the MDS Coordinator RN. The resident was requesting that the Hoyer lift, upright lift, and laundry cart be moved, as they were parked in the hallway in front of his room. The equipment was removed by a CNA at the request of the MDS Coordinator.	F 253	committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 253	Continued From page 8 n. Resident # 8 was admitted to the facility on 02/05/02 with diagnoses of Huntington's chorea, depression, hypothyroidism, and osteoarthritis. On 06/17/08 at 6:50 am, Resident #8 was observed in the west hallway, and the resdient's wheelchair was noted to have an approximate two inch tear in the blue vinyl upholstery. The tear was located in a corner of the right foot cushion. This did not pose a skin tear threat. On 06/18/08 at approximately 2:00 pm, the maintenance man and administrator were advised of the above issues.	F 253	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	F278 **Resident Specific** The ID team reviewed resident #'s 11, 2, 5, and 8 related to completeness and accuracy of the current MDS assessment. Adjustments were made as indicated to validate accuracy and completeness. **Other Residents** The ID team reviewed other MDS assessments to monitor for accuracy and completeness. Adjustments were made as indicated. The ID team reviewed the process for completing assessments and implemented a review for verifying accuracy prior to finalization. **Facility Systems** Residents are assessed upon admission and as required including coding the MDS assessment. The MDS will be completed by the ID team and the RN will review for	

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F 278	Continued From page 9 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that a resident's MDS assessment was accurate and residents' MDS assessments were certified as completed. This applied specifically to 1 of 13 (#11) sampled residents reviewed for MDS accuracy and 3 of 13 (#s 2, 5, & 8) sampled residents reviewed for MDS completion with the signature of a registered nurse. Findings include: 1. Resident #11 was admitted to the facility on 11/16/04 with diagnoses of Huntington's Chorea, depression, and shortness of breath. According to the facility's Incident and Accident reports, Resident #11 was found on the floor mattress with part of her head on the floor. No injury was noted. The Post-Event Assessment documented the event occurred on 12/22/07. The resident's previous and most recent quarterly MDS assessments, dated 2/26/08 and 5/27/08 respectively, documented no history of falls in the last 6 months. On 6/19/08 at 1:30 pm, the surveyor discussed with the Administrator and the MDS coordinator that the MDSs did not reflect that the resident sustained a fall. The MDS coordinator stated, "I must have missed it."	F 278	completeness and sign the tool accordingly. When the assessment is completed, the ID team will review the coding for accuracy before filing in the medical record. **Monitor** The DNS and/or designee will review at least one MDS assessment a week to validate completeness and accuracy. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review the monitoring and may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 278	Continued From page 10	F 278		

2. Resident #5 was admitted to the facility on 5/8/07 with diagnoses of bipolar disorder, renal artery stenosis, diabetes mellitus, and osteoporosis.

During record review on 6/17/08, a 1/31/08 quarterly MDS was noted to be the most recent in the resident's chart. When asked if a more recent MDS had been completed, the MDS coordinator stated there had been a more recent one and that it must have been misfiled. A printout of a 4/22/08 annual MDS was provided to the surveyor. The copy did not contain signatures of persons contributing to the assessment, nor a signature of the RN certifying the document.

No signed 4/22/08 annual MDS assessment was made available to the surveyor during the survey.

3. Resident #4 was admitted to the facility on 4/7/08 with diagnoses of dementia, mood disorder, hypertension, and congestive heart failure.

A review of the initial MDS assessment, dated 4/7/08, revealed the document was unsigned by the registered nurse certifying the assessment had been completed.

4. Resident #8 was admitted to the facility on 02/05/02 with diagnoses of Huntington's chorea, depression, hypothyroidism, and osteoarthritis.

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F 278	Continued From page 11 During record review it was determined the facility failed to have a RN sign and certify the assessment was completed for the resident's quarterly MDS assessment, dated 02/07/08.	F 278	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility did not ensure resident comprehensive care plans were reviewed and revised as needed. Resident #2's care plan was not updated for the use of a gait belt. Resident #5's care plan was not updated to reflect the current status of communication and transfer needs. Resident #8's care plan was not	F 280	F280 **Resident Specific** The ID team reviewed resident #'s 2, 5, and 8 related to care plan updates. The plans of care were updated as indicated. **Other Residents** The ID team reviewed other resident care plans related to being current and accurately reflecting the needs of the resident. The ID team will review resident care plans in detail in conjunction with the quarterly assessment and/or change of condition assessment. Residents will be reviewed over the next quarter. Additionally, LN staff will receive in-service education regarding timely updating the care plan with condition changes. **Facility Systems** Residents are assessed upon admission, with change of condition and at least quarterly.	

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F 280	Continued From page 12 updated for the use of fingerless gloves and the level of assistance required for eating. This was true for 3 of 13 resident (#s 2, 5, & 8) care plans reviewed. Findings include: 1. Resident #5 was admitted to the facility on 5/8/07 with diagnoses of bipolar disorder, renal artery stenosis, diabetes mellitus, and osteoporosis. During observation on 6/17/08 at 8:10 a.m. 2 CNAs transferred the resident from the wheelchair to the commode. The CNAs used a sit to stand mechanical lift for the transfer. Resident #5's 5/18/07 Care Plan, updated to 7/28/08, stated the resident transferred with 1 assist and a gait belt from the wheelchair. Resident #5 was interviewed on 6/16/08 at 2:45 p.m. During the interview, the resident was articulate and easily understood. She had no discernable problem understanding the questions asked or formulating appropriate answers. The 4/22/08 annual MDS documented the resident understood verbal communication, had clear speech, used distinct intelligible words and usually understood others. The 5/18/07 Care Plan, updated to 7/28/08, stated the resident experienced impaired verbal communication related to inability to process and understand language spoken by others, and 1 approach listed was to involve family with the development of a communication plan. The DON and RN consultant were interviewed on 6/18/08 at 2:25 p.m. The DON stated the resident's Comprehensive Care Plan for transfer and communication were in error and needed to	F 280	Based on the assessment, a plan of care is developed and implemented. With subsequent changes in status or condition, the LN or ID team member will update the plan of care as indicated. The change of condition form or three-part tool will be the primary source for updating the plan of care with condition changes. **Monitor** The DNS and/or designee will review at least one plan of care each week to monitor for accuracy. Any concerns will be addressed immediately and discussed with the ID team and PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 280	Continued From page 13 be updated. 2. Resident #2 was admitted to the facility with diagnoses of dementia, depression, diabetes mellitus, hypertension, cerebrovascular accident, and aphasia. The most recent quarterly MDS assessment, dated 6/4/08, documented the resident as having: *short and long term memory problems, *persistent anger with self and others, *verbal abusive tendencies, *resistance to care giving efforts, *need for extensive assistance with ADLs, *conditions/diseases making cognitive, ADL, mood or behavior patterns unstable. The resident's Comprehensive Care Report, dated 3/27/08 with a 9/4/08 goal date, documented the problem of impaired physical mobility with right sided weakness. One of the approaches listed was, "transfer with gaitbelt using 1 assist." Observation of the resident's ADLs on 6/17/08 at 6:15 am, revealed the resident was verbally abusive toward staff and resistant to cares and transfer assistance. The resident did not allow the CNAs to use the gait belt for transfer from the bed to the wheelchair. The CNA was interviewed on 6/18/08 at 10:30 am regarding the resident's care plan indicating gait belt use for transfers. She stated the resident refused transfer assistance with the gait belt more often than not. She stated the LNs were aware of the refusal but had not updated the care plan to reflect the frequent refusals. 3. Resident # 8 was admitted to the facility on 02/05/02 with diagnoses of Huntington's chorea,	F 280	.	

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F 280	Continued From page 14 depression, hypothyroidism, and osteoarthritis. a. The 06/03/08 Comprehensive Care Plan included approaches to, "East (sic) in RNA [restorative nurse aid] with encouragement and setup as indicated," while dining. The care plan also included,"1) SBA [stand by assistance]-Set up with cueing, 2) MIN-Min assist with eating 25%, 3) MOD-Mod assist with eating 50%, 4) MAX- Max assist with eating 75%, 5) Total Assist." However, the care plan failed to differentiate the indicated level of assistance the resident required during meals. b. The 05/22/08 Condition Change form, located within the 05/21/08 Post-Event Assessment form, indicated that the facility,"Will provide fingerless gloves to see if she [the resident] will be comfortable and prevent further injury to hands." However, the 06/03/08 care plan failed to list the intervention, implementation, monitoring, or evaluation of the fingerless gloves in regards to the resident's care. The DON and administrator were interviewed on 06/20/08 at 08:50 am, and advised that the resident's care plan was not updated to reflect the current status of the resident's condition.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	F 315 **Resident Specific** The ID team reviewed resident # 3 related to her continence status completing a comprehensive bladder status assessment. The plan of care was updated as indicated.	

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F 315	Continued From page 15 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to conduct a bowel and bladder assessment when a resident experienced a deterioration in bowel and bladder continence. This applied specifically to 1 of 5 (#3) sampled residents reviewed for incontinence. Findings include: Resident #3 was admitted to the facility on 2/7/07 with diagnoses of traumatic brain injury, mood disorder, anxiety, and dementia. Resident #3's Bowel Retraining Assessment, dated 8/01/07, documented the resident was continent of bowel. Resident #3's annual MDS assessment, dated 1/28/08, documented the resident was continent of bowel and continent of bladder. Resident #3's Bladder Status Evaluation, dated 2/06/08, documented the resident occasionally dribbled urine. Resident #3's ADL Flow Records documented bowel and bladder continence by shifts: February 2008; Incontinent of bowel one out of 87 shifts; Incontinent of bladder 9 out of 87 shifts. March 2008; Incontinent of bowel 26 out of 93 shifts; Incontinent of bladder 78 out of 93 shifts. April 2008; Incontinent of bowel 12 out of 90 shifts; Incontinent of bladder 90 out of 90 shifts.	F 315	**Other Residents** The ID team reviewed other residents with recent changes in bowel and/or bladder continence to monitor for comprehensive assessments and appropriate plans of care. Adjustments were made as indicated. Additionally, nursing staff will receive in-service education related to bowel and bladder assessment and appropriate intervention as indicated. **Facility Systems** Residents are assessed upon admission and with any change in bowel and/or bladder continence. A plan of care is developed based on the comprehensive assessment to address any specific changes in continence. LN staff supervise the implementation of the plan of care daily to monitor for appropriate and timely intervention. **Monitor** The DNS and/or designee will review at least one resident per week related to timely assessment of continence status and intervention. Any concerns will be addressed immediately and discussed with the ID team and PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 315	Continued From page 16 Resident #3's most recent significant change MDS assessment, dated 4/22/08, documented the resident's bowel and bladder conditions had deteriorated to frequently incontinent of bowel and incontinent of bladder. The resident's Comprehensive Care Plan Report, dated 6/3/08, documented the problem of toileting self-care deficit with one goal of , "will complete toileting tasks with 1-2 extensive assist." Three of the problem approaches were, "Allow ample time for tasks. Provide one care as needed...Instruct correct toileting hygiene assist w/ [with] verbal cues q [every] shift & prn [and as needed]...Encourage resident to complete toileting task with cueing assist." The care plan did not include goals or specific approaches to be taken by CNAs to increase the resident's level of continence or to provide care related to the resident's decrease in bowel and bladder continence. On 6/17/08 at 8:00 am, a CNA was observed changing the resident's adult continence brief while the resident was standing with the assistance of a sit-to-stand mechanical lift. On 6/18/08 at 9:15 am, the Assistant DON (ADON) and the surveyor reviewed the differences between the resident's MDSs. The ADON indicated that an updated bowel and bladder assessment should have been completed since the resident had a decline in continence. On 6/20/08 at 7:52 am, the surveyor asked the MDS coordinator what documents were used as the source of information for a resident's bowel and bladder continence. The MDS coordinator	F 315		

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F 315	Continued From page 17 referred to the information documented by the CNAs on the resident's ADL Flow Records. A resident who experienced a deterioration in bowel and bladder continence was not reassessed to reflect their current status.	F 315	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure 1 of 13 sampled residents (#12) was provided adequate supervision to prevent falls to the resident. In addition, an environment free from accident hazards was not provided for 2 of 13 sampled residents (#s 8 & 11). A power cord created a trip hazard for Resident #8. Resident #11's care plan was not followed for the use of a mat on the floor. Findings include: 1. Resident #12 was admitted to the facility on 2/21/08 with diagnoses of psychosis, dementia with behaviors, anemia, gastroesophageal reflux disease, hypothyroidism, mood disorder, and status post hip fracture. Resident #12's most recent quarterly MDS assessment, dated 5/30/08, documented the following:	F 323	F 323 **Resident Specific** The ID team reviewed resident # 12 related to risk for falls and injury. Adjustments have been made to the plan of care as indicated. The power cord was moved and stored appropriately in resident # 8's room. Finally, the mat for resident # 11 was replaced as indicated. **Other Residents** The ID team has reviewed other residents with a history of recent falls to monitor that adjusted plans of care have been implemented as indicated. Additionally, the administrator and maintenance director rounded in the center to validate that no other hazards were present. Finally, in-service education will be provided to center staff regarding validation that no hazards are present and fall prevention is accurately implemented at the bedside.	

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	135014	A. BUILDING _____ B. WING _____	06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALDWELL CARE CTR	210 CLEVELAND BOULEVARD CALDWELL, ID 83605

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F 323	Continued From page 18 *short and long term memory problems, *severely impaired cognitive skills for daily decision making, *wandering tendencies *bladder incontinence, *extensive assistance with one person assist for ADLs, *unsteady gait, *hip fracture in last 180 days, *other fracture in last 180 days, *falls in the last 30 days and within the last 31 to 180 days, *moderate pain, less than daily. The resident's admission fall risk assessment, dated 2/21/08, scored the resident at 22 for fall potential. The fall risk assessment indicated a score greater than 14 was considered high risk. The resident had fallen in December 2007, prior to her admission to the facility, resulting in a fractured hip that was surgically repaired. A RAP for falls was triggered from the resident's 2/28/08 admission MDS assessment. The problem of "at risk for falls" was addressed on the resident's Comprehensive Care Plan Report, dated 3/10/08. Approaches included, "Assess cause, pattern of previous falls and act upon resolvable factors," "Pressure alarm in wheelchair and bed," "Keep adjustable bed in low position for safe transfers." The approach "Provide personal activity items to do" was added to the care plan on 3/17/08. "Direct line of site supervision" was added to the care plan on 5/27/08. According to the documented Post-Event Assessments and Condition Change Forms, the resident had 10 falls between 3/5/08 and 6/19/08.	F 323	**Facility Systems** The facility maintenance director will complete monthly prevention rounds to validate hazards are eliminated. Additionally, staff will address any hazard concern immediately and notify the maintenance director as indicated. Finally, residents are assessed upon admission, with changes in condition and at least quarterly related to risk for falling. A plan of care is developed and modified as indicated. With any resident fall, the ID team carefully reviews it and monitors that an appropriate plan of care is in place. **Monitor** The DNS and/or designee will review at least one resident weekly to validate timely assessment and appropriate plan of care to prevent accidents and incidents. Any concerns will be addressed immediately and discussed with the ID team as indicated. Additionally, the environment will be reviewed as noted above. The PI committee will discuss as indicated and may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 323	Continued From page 19 Two falls resulted in significant resident injury: a nondisplaced pelvic fracture with pain on 5/20/08 and acute cervical strain on 6/9/08. Resident #12's falls documented on the Post-Event Assessment, Post-Event Investigation/Interviews, and Post-Event Action forms were as follows: 1) 3/5/08 at 8:45 pm - Unwitnessed fall, found on floor of dining room after going to bed for the night. Tab alarm had been removed, presumably by resident. Recommendations by the DON: *Change to pressure alarm in bed and wheelchair until more stable *Assist bed only when requested 2) 3/15/08 at 3:30 pm - Unwitnessed fall. Resident was found on floor between wheelchair foot pedals. Alarm sounded. Recommendations by the DON: *Provide activities when up in chair Follow up: "Staff trialed a lap buddy, but res [resident] unable to remove." 3) 4/26/08 at 11:30 am - Unwitnessed fall, resident was found on floor in hallway outside of room. Alarm sounded. Recommendations by the DON: *Engage in activities and have direct supervision when up in wheelchair *Continue tab alarm in wheelchair 4) 4/30/08 at 11:30 am - Slid out of chair triggering alarm, while in direct line of sight of staff. No recommendations were documented.	F 323	.	

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F 323	Continued From page 20 5) 5/2/08 at 2:00 pm - Staff witnessed fall from wheelchair. Alarm sounded. Right knee pain. Recommendations by the ADON: *Physical therapy evaluation for chair cushion *X-ray right knee *Monitor injury *Alert charting Follow up: X-ray results from a mobile imaging service documented, "The knee joint is in alignment...No acute fracture or dislocation is seen." No reference to chair cushion evaluation in Physical Therapy Progress Notes or Resident Progress notes. 6) 5/20/08 at 1:45 pm - Unwitnessed fall from wheelchair in hall. Chair alarm in use. Left hip and lower back pain. [Note: Resident was supposed to have line of sight supervision by staff.] Recommendations by the DON: *Physical therapy evaluation for fracture *Direct supervision after meals *MD to evaluate medications Follow up: X-rays results from a mobile imaging service documented, "Nondisplaced left superior pubic ramus [pelvis] fracture seen. Otherwise normal pelvis." The resident's Condition Change Form, dated and signed by the DON on 5/21/08 documented, "X-rays neg [negative] for injury." The resident's physician ordered medication for anxiety to be given as needed. 7) 5/25/08 at 3:30 pm - Unwitnessed fall from wheelchair in dayroom. Chair alarm in use. Recommendations by the DON: *Direct line of sight supervision *Continue physical therapy with alarm Follow up: "Merry walker not successful." Reasons were not given.	F 323	.	

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F 323	Continued From page 21 8) 6/8/08 at 10:15 am - Staff witnessed fall as resident stood up from wheelchair and fell to the floor. Tab alarm in use. Recommendation by the ADON: *Monitor for injuries for 3 days *Neurological checks *Increase activities 9) 6/9/08 at 5:15 am - In wheelchair by nurse's station, stood up and lost balance falling to floor. Unclear if fall was witnessed. Tab alarm in use. Recommendations by the ADON: *Monitor for injuries *Hip x-ray *Increase activities Follow up: Transported to emergency room. Results from medical facility imaging exams documented hip and leg x-rays were negative for fractures. The cervical spine CT [computed tomography] imaging was also negative. Diagnosed with acute cervical strain. 10) 6/18/08 at 5:30 pm - Staff witnessed fall from wheelchair to dining room floor. Tab alarms were off for meal. Recommendations by the DON: *Activities to focus on small groups *Continue alarm and direct line supervision when out of bed. On 6/19/08 at 3:20 pm, the DON was interviewed regarding Resident #12's fall history. When asked about the facility's practice for increased or direct supervision, the DON stated a resident is placed in an area that can be supervised,"by the nursing station or alcove." The surveyor asked if progression to 1:1 supervision was considered when direct supervision proved ineffective. The DON stated that 1:1 supervision to prevent the	F 323	.	

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F 323	Continued From page 22 resident's falls was "not feasible." However, the DON confirmed that at least one other resident in the facility had been provided with 1:1 supervision due to falls with injury. However, the Post-Event Investigation/Interviews form for the resident's 5/20/08 fall documented the CNAs were "in room 201 laying pts [patients] down when they heard the thud of [resident] falling from her w/c [wheelchair] in hall outside the room door." The indicated area of the resident's fall was not directly visible from the nurses station or alcove and was not witnessed or attended by staff. A resident assessed as a high fall risk on admission to the facility was not monitored to prevent falls. According to the facility's accident report documentation, Resident #12 fell 13 days after being admitted to the facility and fell a total of 10 times from 3/5/08 through 6/18/08. Five of the 10 falls were unwitnessed. After the resident's third fall on 4/26/08, the facility's investigation resulted in the recommendation for "direct supervision when up in wheelchair." One unwitnessed fall on 5/20/08 resulted in a non displaced left superior pubic ramus fracture although the resident's Condition Change Form documented x-rays were negative for injury. Based on record review and staff interview, direct supervision was not provided for the resident's 5/20/08 and 5/25/08 falls. Another fall, on 6/9/08, resulted in the resident's acute cervical strain. That fall occurred at the nurse's station but documentation did not indicate the presence of direct staff supervision. Based on the evidence presented by the facility, Resident #12 was not provided with increased levels of supervision to help decrease or prevent falls which resulted in	F 323		

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F 323	Continued From page 23 injury to the resident on two separate occasions. 2. Resident # 8 was admitted to the facility on 02/05/02 with diagnoses of Huntington's chorea, depression, hypothyroidism, and osteoarthritis. On 06/17/08 at 7:00 am, a pile of electrical cords plugged into a power strip was observed protruding into the floor space of the resident's room. These cords created a trip hazard for the resident, staff and public. The maintenance man and administrator were shown the power strip and electrical cords on 06/18/08 at approximately 1:45 pm, and acknowledged the the cords presented a hazard in the resident's room. 3. Resident #11 was admitted to the facility on 11/16/04 with diagnoses of Huntington's Chorea, depression, and shortness of breath. Resident #11's Comprehensive Care Plan Report, dated 6/09/08, documented the problem of potential for trauma related to Huntington's Chorea and to fall risk, and slid from wheelchair. One of the problem approaches was, "...mat on floor..." The care plan approach was dated 1/04/07. The resident's Nursing Assessment/Partial, dated 6/6/08, documented the resident was a fall risk with a score of 13. A score of 9-13 was considered a moderate fall risk. On 6/19/08 at 11:00 am, the surveyor observed that Resident #11's room did not have a mat on the floor on either side of the bed. On 6/19/08 at 3:00 pm, the surveyor asked the	F 323	.	

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F 323	Continued From page 24 Assistant DON (ADON) about the use of a mat on the floor next to the resident's bed. The ADON stated, "If it is on the care plan, it should be on the floor [next to the resident]." On 6/20/08 at 8:50 am, the surveyor observed the resident laying in bed. There was no mat on the floor next to the resident's bed. The approach of a mat on the floor on a resident's care plan was not followed for a resident who was assessed as a fall risk.	F 323	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure oxygen therapy was administered under a physician's order for 1 of 13 sampled residents (#1). Findings include: Resident #1 was admitted to the facility on 12/1/07 with diagnoses of psychosis, severe dementia Alzheimer's type, non-insulin dependent diabetes mellitus, hypertension, coronary artery	F 328	F 328 Resident # 1 was administered oxygen per a physician telephone order received on 6/15/08. As noted, the order was not fully transcribed into the record, but had been received from the physician to the nurse. The order was clarified on 6/19/08. **Resident Specific** The order for oxygen received on 6/15/08 was reviewed with the physician and clarified on 6/19/08. Resident # 1 discharged from the center. **Other Residents** Other residents receiving oxygen are reviewed by the ID team to validate appropriate and clear physician orders are in place and transcribed in the medical record. LN staff will receive in-service education regarding appropriate and timely physician orders for oxygen therapy.	

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F 328	Continued From page 25 disease, renal insufficiency, and mood disorder. The two most recent quarterly reviews, dated 2/25/08 and 5/26/08, documented the resident as having: *short and long term memory problems, *severely impaired cognitive skills for daily decision making, *wandering tendencies, *bladder incontinence, *need for extensive assistance with one person assist for ADLs, *unsteady gait. On 6/16/08 at 12:45 pm and again at 2:30 pm, the resident was observed in bed with oxygen per non-rebreather mask at 6 liters per minute. The following day, 6/17/08 at 6:10 am, the resident was observed with oxygen per nasal cannula at 3.5 liters per minute which continued through observations on 6/18/08. The review of the resident's 6/08 Physician Orders (recapitulation) and telephone orders revealed there was no order for oxygen therapy. The 6/08 Medication Record and Comprehensive Care Plan Report were also lacking documentation for the administration of oxygen. The Resident Progress Notes for Resident #1 on 6/14/08 at 4:30 pm documented, "O2 [oxygen] sats [saturation] 84 [percent]. Dr. Brown notified. Tylenol suppository given. 02 2 l NC [oxygen at 2 liters per nasal cannula] applied." The Progress Notes referenced the resident receiving oxygen on 6/15/08 at 5:55 pm; 6/16/08 at 3:15 am, 7:30 am and 9:00 pm; 6/17/08 at 3:00 am and 8:30 am; and 6/18/08 at 7:25 am.	F 328	**Facility Systems** Residents are assessed upon admission, with change of condition and at least quarterly. When indicated, oxygen is administered per a physician order. The order is transcribed and carried out by a LN. When indicated, parameters are established per the physician order for adjusting the delivery method, flow and frequency. **Monitor** The DNS and/or designee will review at least one resident weekly that is receiving oxygen therapy to validate appropriate physician orders are in placed and transcribed into the medical record. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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F 328	Continued From page 26 The north wing LN was interviewed on 6/18/08 at 11:20 am. She stated she administered oxygen after the resident had choked on food and required the Heimlich maneuver on 6/15/08 at 5:55 pm. The LN stated she had contacted the resident's physician by telephone to report the incident. The physician gave new orders at that time, but the LN stated she had forgotten to document the oxygen telephone order or update the care plan and Medication Record. On 6/19/08 at 10:40 am, the DON was apprised of the lacking oxygen documentation.	F 328	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 458 SS=D	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident interview, the facility failed to ensure rooms with multiple residents had at least 80 square feet of living space per resident. This affected 3 of 34 resident rooms (#s 111, 112 and 114) that did not meet the minimum requirement of 80 square feet per resident. Findings include: Room 111, occupancy for two residents had 78.6 square feet per resident. Room 112, occupancy for two residents, had 79 square feet per resident. Room 114, occupancy for two residents, had 79.5 square feet per resident.	F 458	F 458 As noted in the statement of deficiency, the center will reapply for a waiver. The center continues to ensure that residents with significant equipment requirements or generally requiring additional space are not placed in these three rooms, #'s 111, 112 and 114. Phone conversation with DON on 7/25/08 @ 8:30 Am Date of Completion: July 25, 2008 KD	

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F 458	Continued From page 27 The facility had a room size requirement waiver for rooms 111, 112 and 114 granted on 4/19/06. This waiver was in effect until the next onsite survey. Observation on 4/17/07 indicated the room occupancy of two residents each had not been reduced, and there was no indication that the rooms' dimensions were increased. The Administrator confirmed the facility's intention to reapply for the waiver during interview on 6/20/08 at approximately 9:30 a.m.	F 458	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 468 SS=E	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that handrails in two of three halls were not firmly affixed to the walls of the facility. Findings include: On 06/17/08 at 7:50 am, it was observed that two handrails in the west hallway outside of room 115, and one handrail in the east hallway outside of the Therapy room, were not firmly affixed to the wall. At approximately 2:00 pm on 06/18/08, the maintenance man and administrator were notified and acknowledged the loose handrails found in the facility.	F 468	F 468 The facility immediately addressed the handrails during the survey process to ensure they were securely affixed to the walls. The administrator and maintenance director rounded in the center to validate the other rails were firmly affixed as required. No other concerns were observed at this time. The handrails will be monitored at least monthly during routine preventive maintenance rounds and tightened as indicated by the maintenance director. Additionally, the administrator will monitor the rails at least weekly. Loose rails will be addressed. Any additional concerns will be resolved with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** July 25, 2008	

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual state licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Rhonda Olsen, RN Lea Stoltz, QMRP Amnda Bain, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Caldwell Care Center does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL 16 2008 FACILITY STANDARDS	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to privacy and dignity.	C 125	Refer to the plan of correction at F 241 Date of compliance: July 25, 2008 KD	
C 129	02.100,03,c,xiii xiii. May retain and use his	C 129		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 129	Continued From page 1 personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients/residents, and unless medically contraindicated (as documented by his physician in his medical record); and This Rule is not met as evidenced by: Refer to F252 as it relates to a homelike environment.	C 129	Refer to the plan of correction at F 252 Date of Compliance: July 25, 2008 KD	
C 156	02.100,08,a a. Patients/residents shall not be transferred or discharged on the attending physician's order without prior notification of next of kin, or sponsor, except in cases of emergency. Patients/residents shall be counselled prior to transfer or discharge. This Rule is not met as evidenced by: Refer to F157 as it relates to notification of room change.	C 156	C 156 Room changes and/or discharge will only be completed upon proper notification and documentation in the record with the exception of emergencies. The DNS and/or designee will monitor for compliance with any room change or discharge and report to the PI committee as indicated. Date of Compliance: July 25, 2008 KD	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F253 as it relates to environment.	C 361	Refer to the plan of correction at F 253 Date of compliance: July 25, 2008 KD	
C 362	02.108,07,a	C 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135014	A. BUILDING _____ B. WING _____	06/20/2008

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C 362	Continued From page 2 a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Refer to F253 as it relates to bathroom sanitation and cleanliness.	C 362	Refer to the plan of correction at F 253 Date of Compliance: July 25, 2008 KD	
C 389	02.120,03,d d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 as it relates to handrails.	C 389	Refer to the plan of correction at F 468 Date of Compliance: July 25, 2008 KD	
C 405	02.120,05,e e. Patient/resident rooms shall be of sufficient size to allow not less than eighty (80) square feet of usable floor space per patient/resident in multiple-bed rooms. Private rooms shall have not less than one hundred (100) square feet of usable floor space. This Rule is not met as evidenced by: Refer to F458 as it related to resident room living space.	C 405	Refer to the plan of correction at F 458 Date of Compliance: July 25, 2008 KD	
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and	C 696		

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C 696	Continued From page 3 emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Refer to F250 as it relates to Social Services.	C 696	Refer to the plan of correction at C 156 Date of Compliance: July 25, 2008 KD	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it refers to bowel and bladder assessments.	C 779	Refer to the plan of correction for F 272 Date of Compliance: July 25, 2008 KD	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Pleas refer to F280 as it relates to care plans.	C 782	Refer to the plan of correction for F 280 Date of Compliance: July 25, 2008 KD	
C 798	02.200,04,a MEDICATION ADMINISTRATION 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse	C 798	Refer to the plan of correction for F 328 Date of Compliance: July 25, 2008 KD	

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C 798	Continued From page 4 practitioner's written orders; This Rule is not met as evidenced by: Please refer to F328 as it refers to the administration of oxygen without a physician's order.	C 798		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to medical records.	C 881	Resident # 12 is not currently utilizing a lap buddy. The plan of care was updated to reflect current needs/interventions. Resident # 15 discharged from the center. When an intervention is determined to be required, adequate assessment and documentation will be reflected in the medical record. Upon discharge, interventions and preparation including planning will be appropriately reflected in the medical record. The DNS and/or designee will monitor for compliance weekly and report to the PI committee as indicated. The PI committee may adjust the frequency as needed. Compliance will be July 25, 2008.	